

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

538

CERTIFICATE OF DEATH

00531

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Physicans Memorial Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle ELI Last BRADBURN		4. DATE OF DEATH Month Jan Day 10 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Bradburn		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph F. Bradburn Grand-son , La Plata , Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage 581.0 DUE TO cirrhosis of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-59 to 1-10-59 , that I last saw the deceased alive on 1-10-59 , and that death occurred at 11:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE F.M. Johnson M.D.		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 1-10-59	
PHYSICIAN'S NAME (Type) F.M. JOHNSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/1959	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	22d. LOCATION (City, town, or county) (State) La Plata , Charles Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA , MD.		24a. REC'D BY REGISTRAR JAN 14 '59 DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Duration of illness	
9. Name of physician		10. Name of attending physician		11. Name of hospital		12. Name of funeral home	
13. Name of informant		14. Name of registrar		15. Name of witness		16. Name of undertaker	
17. Name of cemetery		18. Name of church		19. Name of school		20. Name of place of birth	
21. Name of place of residence		22. Name of place of birth		23. Name of place of birth		24. Name of place of birth	
25. Name of place of birth		26. Name of place of birth		27. Name of place of birth		28. Name of place of birth	
29. Name of place of birth		30. Name of place of birth		31. Name of place of birth		32. Name of place of birth	
33. Name of place of birth		34. Name of place of birth		35. Name of place of birth		36. Name of place of birth	
37. Name of place of birth		38. Name of place of birth		39. Name of place of birth		40. Name of place of birth	
41. Name of place of birth		42. Name of place of birth		43. Name of place of birth		44. Name of place of birth	
45. Name of place of birth		46. Name of place of birth		47. Name of place of birth		48. Name of place of birth	
49. Name of place of birth		50. Name of place of birth		51. Name of place of birth		52. Name of place of birth	
53. Name of place of birth		54. Name of place of birth		55. Name of place of birth		56. Name of place of birth	
57. Name of place of birth		58. Name of place of birth		59. Name of place of birth		60. Name of place of birth	
61. Name of place of birth		62. Name of place of birth		63. Name of place of birth		64. Name of place of birth	
65. Name of place of birth		66. Name of place of birth		67. Name of place of birth		68. Name of place of birth	
69. Name of place of birth		70. Name of place of birth		71. Name of place of birth		72. Name of place of birth	
73. Name of place of birth		74. Name of place of birth		75. Name of place of birth		76. Name of place of birth	
77. Name of place of birth		78. Name of place of birth		79. Name of place of birth		80. Name of place of birth	
81. Name of place of birth		82. Name of place of birth		83. Name of place of birth		84. Name of place of birth	
85. Name of place of birth		86. Name of place of birth		87. Name of place of birth		88. Name of place of birth	
89. Name of place of birth		90. Name of place of birth		91. Name of place of birth		92. Name of place of birth	
93. Name of place of birth		94. Name of place of birth		95. Name of place of birth		96. Name of place of birth	
97. Name of place of birth		98. Name of place of birth		99. Name of place of birth		100. Name of place of birth	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ERNEST</u> First <u>HERBERT</u> Middle <u>FRAZIER</u> Last <u>JR.</u>		4. DATE OF DEATH <u>JAN.</u> Month <u>24</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1932</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Herbert Frazier</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wilkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ernest Frazier</u>		Address <u>1747 E St SE, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 825X DUE TO (b) <u>Basilar Skull Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Fractured Cervical Vertebrae</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Cervical Vertebrae</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>15 min.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:45</u> <u>1-24</u> <u>1959</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Indian Head, Charles, Md.</u> (County) (State)
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V.B. Detton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Washington</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnant Jenkins</u>		ADDRESS <u>Fun Home 4804 G St NW</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Amey</u>	
DATE <u>JAN 27 59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0110-0001

THE NO. 100 CLUB

CERTIFICATE OF DEATH

00533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Doncaster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Doncaster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle <i>Elizabeth</i> Last <i>Gilroy</i>		4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-82</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Nanjing, old</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Murphy</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Dodd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. W. W. Moore, Rt. 1 Box 454 Indian Head</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus, old.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 yrs.</i> <i>3 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 17</i> , 19 <i>55</i> , to <i>Jan 17</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 17</i> , 19 <i>59</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank G. Person</i>		DATE SIGNED <i>1/18/59</i>	
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>		ADDRESS (Street, city or town, state) <i>Indian Head, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-20-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gilroy Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Doncaster Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home, Waldorf Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Knapp</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>JAN 23 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

007-33

CERTIFICATE OF DEATH

File No.

540

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

SEX

AGE

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF BIRTH

DATE

TIME

PLACE OF BIRTH

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TIME

RECEIVED IN P. S. L.

RECEIVED IN P. S. L. (Vertical stamp on the right margin)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsides Md</u>				c. LENGTH OF STAY IN 1b <u>4-Mths</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Julia Ann Hart</u> First Middle Last				4. DATE OF DEATH <u>2-20-59</u> 1-7-59 Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-58</u>	9. AGE (In years last birthday) <u>4-Mths</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Charles Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm. James Hart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Agnes Cobey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother Mary Agnes Hart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia-Broncho</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory infection</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2-Days</u> <u>2-Weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-6-59</u> , 19 <u>59</u> , to <u>1-7-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-7-59</u> , 19 <u>59</u> , and that death occurred at <u>8-45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Indian Head Md</u> DATE SIGNED <u>1-7-59</u>							
ACTUAL SIGNATURE <u>James E. Andrews MD</u>				PHYSICIAN'S NAME (Type) <u>Indian Head Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/9/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Church</u>		22d. LOCATION (City, town, or county) <u>Seaside Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins</u>				ADDRESS <u>4801 G. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kana</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

542

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pisgah		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAN Middle HENSON Last HENSON		4. DATE OF DEATH Month January Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-96
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) laborer	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Henson		14. MOTHER'S MAIDEN NAME Josephine Marbury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 903 Howard Rd SE	
17. INFORMANT Emma Lewis		Address 903 Howard Rd SE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found drowned (c) Found drowned			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned	
20c. TIME OF INJURY Month, Day, Year Hour Unknown 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water	20f. (City or town) Charles (County) Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, J., M.D.		DATE SIGNED 1/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-25-59	22c. NAME OF CEMETERY OR CREMATORY Smith Chapel	22d. LOCATION (City, town, or county) Pisgah, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. ...		24a. REC'D BY REGIS. RAN SA 24b. REGISTRAR'S SIGNATURE SA	

HEALTH UNIT

[Faint, mostly illegible text and markings on the form, including what appears to be a signature in the lower right section.]

NEW CHURCH

343

CERTIFICATE OF DEATH

00536

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Victoria			
				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle HUGHES Last HUGHES				4. DATE OF DEATH Month Jan Day 23 Year 1959			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Common Labor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carrol Hughes				14. MOTHER'S MAIDEN NAME Lettie Chapman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Marie Brown, Mt Victoria, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Sanguine of feet DUE TO fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) freezing temp.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Living in an unheated house for 2 weeks during sub-			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Charles Md.	
21. I certify that I attended the deceased from 1-17 , 19 59 to 1-23 , 19 59 , that I last saw the deceased alive on 1-22 , 19 59 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. M. Johnson				ADDRESS (Street, city or town, state) La Plata, Md.			
PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.				DATE SIGNED 1-25-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Shilo		22d. LOCATION (City, town, or county) (State) Mt Victoria Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walt F. H. Waldorf				24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE Carroll E. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00537

544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUB-STATION RD.</u>		d. STREET ADDRESS <u>SUB-STATION RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT MARVIN HYDE</u>		4. DATE OF DEATH Month Day Year <u>JAN 14 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 28 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>DIST of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Hyde</u>		14. MOTHER'S MAIDEN NAME <u>MARY WILKERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>MARY WILKERSON HYDE</u>		Address <u>WALDORF MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>overwhelming signs</u> <u>752X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hydrocephalic from Birth</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-13</u> , 19 <u>58</u> , to <u>1-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-13</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard W. Dobson</u> M.D.		ADDRESS (Street, city or town, state) <u>Bridgman Md</u> DATE SIGNED <u>1-14-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

2000

Form 100-1

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Race: *White*

4. Date of birth: *10/15/1925*

5. Place of birth: *Baltimore, Maryland*

6. Date of death: *11/10/1998*

7. Time of death: *10:30 AM*

8. Place of death: *Home*

9. Cause of death: *Heart Disease*

10. Manner of death: *Natural*

11. Signature of physician: *Dr. J. Smith*

12. Signature of registrar: *John Doe*

13. Signature of informant: *John Doe*

14. Signature of funeral director: *John Doe*

15. Signature of medical examiner: *John Doe*

16. Signature of coroner: *John Doe*

17. Signature of health officer: *John Doe*

18. Signature of state health officer: *John Doe*

19. Signature of federal health officer: *John Doe*

20. Signature of international health officer: *John Doe*

21. Signature of local health officer: *John Doe*

22. Signature of county health officer: *John Doe*

23. Signature of city health officer: *John Doe*

24. Signature of town health officer: *John Doe*

25. Signature of village health officer: *John Doe*

26. Signature of hamlet health officer: *John Doe*

27. Signature of school health officer: *John Doe*

28. Signature of college health officer: *John Doe*

29. Signature of university health officer: *John Doe*

30. Signature of hospital health officer: *John Doe*

31. Signature of nursing home health officer: *John Doe*

32. Signature of residential care facility health officer: *John Doe*

33. Signature of long-term care facility health officer: *John Doe*

34. Signature of health care provider: *John Doe*

35. Signature of health care provider: *John Doe*

36. Signature of health care provider: *John Doe*

37. Signature of health care provider: *John Doe*

38. Signature of health care provider: *John Doe*

39. Signature of health care provider: *John Doe*

40. Signature of health care provider: *John Doe*

41. Signature of health care provider: *John Doe*

42. Signature of health care provider: *John Doe*

43. Signature of health care provider: *John Doe*

44. Signature of health care provider: *John Doe*

45. Signature of health care provider: *John Doe*

John Doe

John Doe

John Doe

545

CERTIFICATE OF DEATH

00538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>X Rural La Plata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicans Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kostka</u> Middle <u>Stanislaus</u> Last <u>JAMESON</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>	IF UNDER 24 HRS. Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee Retired U.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Charles Co., Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Napolian Jameson</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Sanders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Stanley Jameson (Son)</u> Address <u>La Plata, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal obstruction</u> DUE TO <u>Chronic Interstitial Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic Cirrhosis</u> DUE TO (c) <u>Hepatic Cirrhosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>6 MOS.</u> <u>1 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Operation 12-5-58: Cholecystoduodenostomy performed.</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1, 1958</u> to <u>Jan 7, 1959</u> , that I last saw the deceased alive on <u>Jan 7, 1959</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. PARRAN JARBOE</u>				ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>1-7-59</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE</u>				<u>LA PLATA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ceder Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Prince Geo., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home</u>				ADDRESS <u>La Plata, Md.</u>		24a. REC'D BY REGISTRAR <u>AN 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony S. Krasa</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOYD

<p>1. Name of deceased: WILLIAM BOYD</p>		<p>2. Date of death: []</p>	
<p>3. Place of death: []</p>		<p>4. Cause of death: []</p>	
<p>5. Age at death: []</p>		<p>6. Sex: []</p>	
<p>7. Marital status: []</p>		<p>8. Occupation: []</p>	
<p>9. Signature of physician: []</p>		<p>10. Signature of registrar: []</p>	
<p>11. Date of registration: []</p>		<p>12. Place of registration: []</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G237 1-21-59 et

CERTIFICATE OF DEATH

00539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LA PLATA		d. STREET ADDRESS Washington St, Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) "At home"		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle S Last LORENZ		4. DATE OF DEATH Month Jan Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE U.S.W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus M. Hyde		14. MOTHER'S MAIDEN NAME Minnie S. Squires	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Mrs. Frances Winkler (Daughter) - La Plata, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.V.A. DUE TO General debilitation (c) Change of the Central nervous system, Kidney infection		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) degenerative disease of the cerebellum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to 12 Jan , 19 59 , that I last saw the deceased alive on 12 January , 19 59 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Woody M.D. La Plata, Md.		DATE SIGNED 13 Jan 59	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/15/1959	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	22d. LOCATION (City, town, or county) (State) La Plata, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD.		24a. REC'D BY REGISTRAR DATE JAN 14 '59	
24b. REGISTRAR'S SIGNATURE Quinn E. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00540

547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown				c. LENGTH OF STAY IN TB Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle LYLES Last LYLES				4. DATE OF DEATH Month Jan Day 22 Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 10, 1880	
				9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alfred Jenifer				14. MOTHER'S MAIDEN NAME Jennie Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William H. Lyles, Bryantown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO-SCLEROSIS DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 24 YEARS 104 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JUNE 1948 to JANUARY 22 1959 , that I last saw the deceased alive on JANUARY 20, 1959 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Griffin M.D. Box 651 HUGHESVILLE, MD. 1/24/59							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-59		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Bryantown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland				24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>ASHBY</i> First <i>LEE</i> Middle <i>MALONE</i> Last		4. DATE OF DEATH <i>JAN</i> Month <i>5</i> Day <i>1959</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1-17-1896</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Ashby</i>		14. MOTHER'S MAIDEN NAME <i>Malone</i> Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Pauline Bailey</i> Address <i>Rock Point Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> <i>331X</i> DUE TO (b) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> <i>15 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>at home</i>	
20c. TIME OF INJURY Month, Day, Year <i>1-5 1959</i> Hour <i>11:30</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Rock Point, Charles, Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V.B. Detton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>1-9-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Columbia Heights</i>		22d. LOCATION (City, town, or county) (State) <i>Columbia Heights Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wickert Inc. Topola Md.</i>		24a. REC'D BY REGISTRAR <i>IAN 1 2 '59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIA First OWENS Middle Last 4. DATE OF DEATH Month 1 Day 1 Year 1959		5. SEX F 6. COLOR OR RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE 33 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAM SMITH		14. MOTHER'S MAIDEN NAME CAROLINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT MARY OWENS NANJEMOY		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Acc 11-58 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 1957			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. EDLEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-1-59	
EXAMINER'S NAME (Type) E. J. EDLEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. (BURIAL, CREMATION, REMOVAL) (Specify) 1/3/59		22b. DATE THREE	
22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) NORTH HARBORLAND County, Va	
23. FUNERAL DIRECTOR'S SIGNATURE Salmon & Jenkins 4004 Lakewood		ADDRESS	
24a. REC'D BY REGISTRAR JAN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MR
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newport</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newport</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>ROBERT</u> Middle <u>PINKNEY</u> Last		4. DATE OF DEATH <u>1</u> Month <u>10</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-58</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months <u>X</u> Days <u>23</u> Hours <u>00</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT MC KINLEY PINKNEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY MADELINE KNOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>Robert Pinkney - Newport, Md.</u>	
17. INFORMANT <u>Robert Pinkney - Newport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1-8-59</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town or county) (State) <u>Newport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Funeral Home Inc</u>		ADDRESS <u>Chesapeake</u>	
DATE <u>AN 1 4 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

4000259XV2

551

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CHARLES. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Chas.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural. White Plains	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First VIVIAN Middle E Last ROBERTS		4. DATE OF DEATH Month January Day 28 Year 1959.	
5. SEX Male	6. COLOR OR RACE U.S.W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road Com.		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Chas Co, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Roberts	
14. MOTHER'S MAIDEN NAME Sarah Lyon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-38-2996		17. INFORMANT Elsbeth Roberts, White Plains Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Respiratory Collapse DUE TO (b) Pneumonia, Lobar DUE TO (c) Emphysema, alveolar.		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 3 days. 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 59 , to Jan 28 , 19 59 , that I last saw the deceased alive on 28 Jan , 19 59 , and that death occurred at 3:28 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Woody		DATE SIGNED 28 Jan 59	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, M.D.		ADDRESS (Street, city or town, state) La Plata, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 1-30-1959	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Waldorf, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR FEB 2 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw		24c. REGISTRAR'S NAME Arthur S. Kraw	

CERTIFICATE OF DEATH

Form No. 100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH Jan 15, 1888	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 15, 1910	
9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH Jan 15, 1953	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE J. H. Smith, M.D.		16. COUNTY Baltimore	
17. CITY Baltimore		18. STATE Maryland	
19. ZIP CODE 21201		20. REGISTRAR'S SIGNATURE John Doe	
21. DATE OF REGISTRATION Jan 16, 1953		22. OFFICIAL SEAL	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00545

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rison</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Rison</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Berdie</i> First Middle Last <i>Smallwood</i>		4. DATE OF DEATH <i>January 23 1959</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 16, 1893</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Rison, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U-S.</i>	
13. FATHER'S NAME <i>John Neal</i>		14. MOTHER'S MAIDEN NAME <i>Susan D. Sted</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Joseph Smallwood</i> Address <i>Rison Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank G. Pusan</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Frank A. Susen M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-27-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chas. com. Alexan. drin chapel</i>		22d. LOCATION (City, town, or county) <i>ME</i> (State) <i>md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Brothers</i>		ADDRESS <i>913 Fla. av. s.w. Wash. D.C.</i>	
DATE <i>1-27-59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. France</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
MANNER OF DEATH		CAUSE OF DEATH		EFFECT OF DEATH		MEDICAL HISTORY		SOCIAL HISTORY	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		LABORATORY TESTS		POST-MORTEM EXAMINATION	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		COUNTY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00546

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THEODORE OLIVER STRINGER</u>			4. DATE OF DEATH Month Day Year <u>January 14, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>July 10, 1914</u>		9. AGE (in years and birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland (Charles County)</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph L. Stringer</u>			14. MOTHER'S MAIDEN NAME <u>Lucy V. (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT (Son) Address <u>Pomonkey, Md.</u> <u>Mr. Joseph L. Mr. Walter K. Stringer</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Acute</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerosis Generalized</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Pomonkey, Charles Co., Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>E. J. Edelen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>January 15, 1959</u>		
EXAMINER'S NAME (Type) <u>E. J. Edelen</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Metropolthen Cemetery</u>		
22d. LOCATION (City, town, or county) (State) <u>Pomonkey, Charles Co., Md.</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc. La Plata, Md.</u>			24a. REC'D BY REGISTRAR <u>DATE JAN 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or to the State Health Department. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

554 CERTIFICATE OF DEATH

00547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pomfret	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last SWANN				4. DATE OF DEATH Month January Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1958	
9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Charles County, Md.	
13. FATHER'S NAME Joseph L. Swann				14. MOTHER'S MAIDEN NAME Cecelia Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Joseph L. Swann (Father) - Pomfret, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7640 Chronic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infectious Diarrhea DUE TO (c) 1-13-59 1-10-59							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) La Plata, Maryland	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-10-59 , to 1-15-59 , that I last saw the deceased alive on 1-14-59 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED							
ACTUAL SIGNATURE E. J. Edelen M.D.				PHYSICIAN'S NAME (Type) E. J. Edelen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/1959		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Pomfret, Charles Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. * LA PLATA, MD				24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00548

555 CERTIFICATE OF DEATH

Item 1 FilmG238 2-13-59 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		STATE <u>MARYLAND</u>		COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Waldorf</u>		LENGTH OF STAY (in this place) <u>D.O.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Enroute to Hopkins Hosp., Balto.</u>				STREET ADDRESS (If rural give location) <u>353 Chinlee Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Boy Baby</u> (Middle) <u>Tatman</u> (Last)				(Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 4, 1959</u>	9. AGE last birthday yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank J. Tatman</u>				14. MOTHER'S MAIDEN NAME <u>Marilyn A. Deiotte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Frank J. Tatman 353 Chinlee Drive Lexington Park, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>776x</u> IMMEDIATE CAUSE (A) <u>Prematurely</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>-----</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-----</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-----</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-----</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-----</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-----</u>			
22. I hereby certify that I attended the deceased from <u>1/4</u>, 19<u>59</u>, to <u>1/4</u>, 19<u>59</u>, that I last saw the deceased alive on <u>1/4</u>, 19<u>59</u>, and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1/6/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/5/59</u>		NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		LOCATION (City, town, or county) <u>Leonardtwn, Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>			
DATE <u>JAN 8 '59</u>		ADDRESS <u>Leonardtwn, Md.</u>					

1000242XUV

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH. IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH, WHO IS TO SIGN IT. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH. IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH, WHO IS TO SIGN IT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12 222 CERTIFICATE OF DEATH

Rev. 12-1-74

1. NAME OF DECEASED (Print or Write)

MARYLAND

CITY OF BALTIMORE

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2. SEX (Print or Write)

3. AGE (Print or Write)

4. DATE OF BIRTH (Print or Write)

5. PLACE OF BIRTH (Print or Write)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. SIGNATURE OF PHYSICIAN (Print or Write)

10. SIGNATURE OF REGISTRAR (Print or Write)

11. SIGNATURE OF WITNESS (Print or Write)

12. SIGNATURE OF WITNESS (Print or Write)

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58. SIGNATURE OF WITNESS (Print or Write)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00549

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head, Md</u>		c. LENGTH OF STAY IN 1b <u>6</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> First <u>A</u> Middle <u>TOWNSHEND</u> Last			4. DATE OF DEATH Month <u>JAN.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1937</u>		9. AGE (In years last birthday) <u>21</u> yrs.	
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing & Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Howard A Townshend</u>			14. MOTHER'S MAIDEN NAME <u>Dorothy Lomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-36-3070</u>		17. INFORMANT <u>Howard A Townshend Bel Alton Md</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Basilar Skull Fracture</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Cervical Vertebrae</u> (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 3 min.</u> <u>1 hr. 3 min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident - Head on</u>				
20c. TIME OF INJURY Month, Day, Year <u>1-24 1959</u> Hour <u>12:45</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		
				20f. (City or town) <u>Indian Head, Charles, Md.</u> (County) (State)		
19. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-24-59</u>		
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace</u>		
22d. LOCATION (City, town, or county) <u>Bel Alton</u>		(State) <u>Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Howard</u> ADDRESS <u>Arthur L. Howard</u>		24a. REC'D BY REGISTRAR <u>JAN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *10/15/1918*

5. Place of death: *Home*

6. Cause of death: *Heart failure*

7. Manner of death: *Natural*

8. Signature of medical examiner: *[Signature]*

9. Signature of physician: *[Signature]*

10. Signature of coroner: *[Signature]*

11. Signature of registrar: *[Signature]*

12. Signature of undertaker: *[Signature]*

13. Signature of funeral home: *[Signature]*

14. Signature of cemetery: *[Signature]*

15. Signature of other: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

557

CERTIFICATE OF DEATH

00550

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bennsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bennsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Woodland</u> Last <u>Woodland</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1872</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Martha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>John M. Fenwick, Wash 24 D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTEROSCLEROSIS GENERAL</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC DISEASE</u> DUE TO (c) <u>CEREBROSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u> <u>1 1/2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>0</u> a. m. <u>19</u> p. m.	Month <u>1</u>	Day <u>31</u>	Year <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 1</u> , 19 <u>58</u> , to <u>JANUARY 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JANUARY 29</u> , 19 <u>59</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>ACCOKEEK, MD.</u> <u>1-29-59</u>			
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Pomfret, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Krawe</u>	

CERTIFICATE OF DEATH

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MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1915

Page One

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. PLACE OF DEATH [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
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